**ARC 3790C**

# HUMAN SERVICES DEPARTMENT[441]

**Adopted and Filed**

**Rule making related to rate-setting methodology**

The Human Services Department hereby amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 83, "Medicaid Waiver Services," Iowa Administrative Code.

*Legal Authority for Rule Making*

This rule making is adopted under the authority provided in Iowa Code section 249A.4 and 2017 Iowa Acts, House File 653, section 93.

*State or Federal Law Implemented*

This rule making implements, in whole or in part, Iowa Code section 249A.4 and 2017 Iowa Acts, House File 653, section 93.

*Purpose and Summary*

These amendments change the rate-setting methodology used to develop supported community living (SCL), day habilitation, and adult day care service rates in the home- and community-based services (HCBS) intellectual disability waiver. The SCL methodology is changed from the retrospectively limited prospective rate-setting process to a fee schedule using a tiered-rate methodology. Day habilitation and adult day care service rates established through a fee schedule are changed to a fee schedule using tiered rates. The tiered-rate methodology establishes a tiered system of reimbursement based on the acuity level identified from the results of the Supports Intensity Scale® (SIS) core standardized assessment.

*Public Comment and Changes to Rule Making*

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on December 6, 2017, as **ARC 3476C**. This rule making was also Adopted and Filed Emergency and published in the Iowa Administrative Bulletin as **ARC 3481C** on the same date. An Amended Notice of Intended Action to provide for two public hearings was published in the Iowa Administrative Bulletin on January 31, 2018, as **ARC 3602C**.

A public hearing was held on February 21, 2018, at 1 p.m. at the Coralville Public Library, E. Jean Schwab Auditorium, 1401 Fifth Street, Coralville, Iowa, and a second public hearing was held on February 23, 2018, at 1:30 p.m. at the Nesler Centre, Third Floor Conference Room, 799 Main Street, Dubuque, Iowa.

The Department consolidated the comments received from the public regarding **ARC 3476C** and **ARC 3481C** into a single document that also includes responses from the Department. The comments consisted of concerns in one of three groups. The first group of comments received when the Department filed the initial Notice of Intended Action requested that the Department conduct public hearings on the rule making. The second group of comments received dealt primarily with the perceived impact of the implementation of the amendments on individual cases. The final group of comments dealt with proposed technical changes to the administrative rules. All of the consolidated comments and the Department's responses are published in a document posted to the Department's website at dhs.iowa.gov/sites/default/files/ARC%203476C%20and%20ARC%203602C%20Comments%20and%20Responses.pdf.

As a direct result of the comments received during the public comment period and technical review of the amendments, the following changes from the Notice and Adopted and Filed Emergency rule makings have been made:

1. The Department further amended the introductory paragraph of 78.41(1)"f" in Item 1 by striking the words "reflect all staff-to-member ratios and shall" and the phrase "for travel and transportation, consulting, instruction, and environmental modifications and repairs," so that the introductory paragraph will read as follows:

"*f.* Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:"

2. The Department added a new Item 3 to amend subrule 78.41(12) and has renumbered subsequent items accordingly. The amendment to subrule 78.41(12) pertains to units of service for adult day care services under the HCBS intellectual disability waiver.

3. The Department further amended the "supported community living" entry under the HCBS waiver service provider listing in subrule 79.1(2) in Item 5 to revise the basis-of-reimbursement statement for the intellectual disability waiver by adding the following: "Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)."

4. The Department further amended the introductory paragraph of subrule 79.1(15) in Item 6 by adding the words "HCBS intellectual disability waiver supported community living for 15-minute services" so that the introductory paragraph will read as follows:

"**79.1(15)** *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency."

5. The Department revised the introductory paragraph of paragraph 79.1(30)"d" in Item 7 to clarify the meaning of "SIS activities score" by changing the phrase "the sum total of scores" to "the sum total of the subscale raw SIS scores converted to standard scores." The introductory paragraph will read as follows:

"*d.* For this purpose, the 'SIS activities score' is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:"

6. The Department revised paragraph 79.1(30)"h" in Item 7 by deleting subparagraph (3), which read:

"(3) A member's acuity tier assignment does not affect the services that the member will receive and is not considered an adverse action, and therefore there are no appeal rights."

7. The Department revised paragraph 83.67(4)"i" in Item 8 by adding the word "standard" before the word "scores" in the introductory paragraph and in subparagraph (3) so that paragraph 83.67(4)"i" will read as follows:

"*i.* For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:

"(1) Score on subsection 1A: Exceptional Medical Support Needs.

"(2) Score on subsection 1B: Exceptional Behavioral Support Needs.

"(3) Sum total of standard scores on the following subsections:

"1. Subsection 2A: Home Living Activities;

"2. Subsection 2B: Community Living Activities;

"3. Subsection 2E: Health and Safety Activities; and

"4. Subsection 2F: Social Activities."

*Adoption of Rule Making*

This rule making was adopted by the Council on Human Services on April 11, 2018.

*Fiscal Impact*

The move to tiered rates as a funding methodology will be cost neutral to the Department. The tiered-rate funding methodology assigns a standardized service rate based on member need, unlike the current methodology of services reimbursement based on provider costs. With this change, some providers will see increased revenues compared to current service reimbursement and other providers will see decreased revenues.

*Jobs Impact*

After analysis and review of this rule making, no impact on jobs has been found.

*Waivers*

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

*Review by Administrative Rules Review Committee*

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

*Effective Date*

This rule making will become effective on June 13, 2018, at which time the Adopted and Filed Emergency amendments are hereby rescinded.

The following rule-making actions are adopted:

ITEM 1. Amend paragraph **78.41(1)"f,"** introductory paragraph, as follows:

*f.* Provider budgets shall ~~reflect all staff-to-member ratios and shall~~ reflect costs associated with members' specific support needs ~~for travel and transportation, consulting, instruction, and environmental modifications and repairs,~~ as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, ~~the total costs shall not exceed $1570 per member per year,~~ and the provider must maintain records to support the expenditures. A unit of service is:

ITEM 2. Amend subrule 78.41(11) as follows:

**78.41(11)** *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed ~~simultaneously with~~ when HCBS intellectual disability waiver daily supported community living service ~~when the transportation costs are included within the supported community living reimbursement rate~~ is authorized in a member's service plan.

ITEM 3. Amend subrule 78.41(12) as follows:

**78.41(12)** *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to ~~8~~ 12 hours per day)~~, or an extended day (8.25 to 12 hours per day)~~. Components of the service include health-related care, social services, and other related support services.

ITEM 4. Amend paragraph **79.1(1)"c"** as follows:

*c. Fee schedules.* Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: ~~http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html~~ dhs.iowa.gov/ime/providers/csrp/fee-schedule.

ITEM 5. Amend subrule 79.1(2), provider category "HCBS waiver service providers," paragraphs "1," "18," "25" and "26," as follows:

**79.1(2)** *Basis of reimbursement of specific provider categories.*

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| 1. Adult day care | For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers:<br>Fee schedule | Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or $1.47 per 15-minute unit, $23.47 per half day, $46.72 per full day, or $70.06 per extended day if no Veterans Administration contract. |
| | For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30) | Effective ~~7/1/16~~ 7/1/17, for intellectual disability waiver: ~~County contract rate or, in the absence of a contract rate,~~ The provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute~~,~~ or half-day~~, full-day, or extended-day~~ rate. If no 6/30/16 rate, $1.96 per 15-minute unit~~,~~ or $31.27 per half day~~, $62.42 per full day, or $79.59 per extended day~~. |

| | | |
|---|---|---|
| | | For daily services, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30). |
| 18. Supported community living | For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15) | For ~~intellectual disability and~~ brain injury waiver effective 7/1/16: $9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%. |
| | For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15) | For intellectual disability waiver effective 7/1/17: $9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30). |
| 25. Residential-based supported community living | ~~Retrospectively limited prospective rates. See 79.1(15)~~ Fee schedule for the member's acuity tier, determined pursuant to 79.1(30) | Effective ~~7/1/16~~ 7/1/17: ~~Not to exceed the maximum ICF/ID rate per day plus 3.927%.~~ The fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30). |
| 26. Day habilitation | Fee schedule for the member's acuity tier, determined pursuant to 79.1(30) | Effective ~~7/1/16~~ 7/1/17: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute ~~or daily~~ rate. If no 6/30/16 rate: $3.51 per 15-minute unit ~~or $68.23 per day~~. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30). |

ITEM 6. Amend subrule 79.1(15) as follows:

**79.1(15)** *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

*a.* No change.

*b. Home- and community-based general rate criteria.*

(1) to (4) No change.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year for supported community living services in the brain injury waiver.

(6) to (9) No change.

*c.* to *g.* No change.

ITEM 7. Adopt the following **new** subrule 79.1(30):

**79.1(30)** *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1)*"c"* provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

*a.* Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

*b.* The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

*c.* For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

*d.* For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

*e.* Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30)*"f"* and *"g,"* are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

*f.* Subject to adjustment pursuant to paragraph 79.1(30)*"g,"* acuity tiers are the highest applicable tier pursuant to the following:

(1) Tier 1: SIS activities score of 0 – 25.

(2) Tier 2: SIS activities score of 26 – 40.

(3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.

(4) Tier 4: SIS activities score of 45 or higher.

(5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.

(6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.

(7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.

(8) RBSCL tier: Members residing in a residential-based supported community living (RBSCL) facility.

(9) Enhanced tier: An individual member rate negotiated between the department and the provider.

*g.* The tier determined pursuant to paragraph 79.1(30)*"f"* shall be adjusted as follows:

(1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)*"e"*(1), but with a response of "extensive support needed" (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)*"e"*(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by two tiers.

(4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)*"f,"* the tier is increased by one tier.

(5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.

*h.* Tier redetermination. A member's acuity tier may be changed in the following circumstances:

(1) There is a change in the member's SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).

(2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member's support needs. A member's case manager may request an emergency needs assessment when a significant change in the member's needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member's acuity tier.

*i.* New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers, or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)*"c."*

ITEM 8. Adopt the following **new** paragraph **83.67(4)"i"**:

*i.* For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:

(1) Score on subsection 1A: Exceptional Medical Support Needs.

(2) Score on subsection 1B: Exceptional Behavioral Support Needs.

(3) Sum total of standard scores on the following subsections:

1. Subsection 2A: Home Living Activities;
2. Subsection 2B: Community Living Activities;
3. Subsection 2E: Health and Safety Activities; and
4. Subsection 2F: Social Activities.

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